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### **Abstract**

*Rationale.* Women on opioid substitution treatment (WOST) are at high risk for sexually transmitted infections and blood-borne viruses (HIV, Hepatitis B and C). This heightened risk is rooted in social and health inequities. Experiencing stigma is considered to have an important role in maintaining these inequities and is a barrier to promoting sexual health. *Objective.* The aims of this study were to explore (1) the experiences of stigma of WOST, and (2) how experiencing stigma may influence women's sexual health. *Method.* Twenty semi-structured interviews with WOST were conducted between October 2016 and April 2017 in South West England (UK). Data were analysed using Framework Analysis. *Results.* Women's narratives highlighted the intersection of stigma associated with distinct elements of women's identities: (1) female gender, (2) drug use, (3) transactional sex, (4) homelessness, and (5) sexual health status. Intersectionality theory and social identity theory are used to explain sexual health behaviours and disengagement from (sexual) health services among WOST. Intersectional stigma was related to a lack of female and male condom use and a lack of access to (sexual) health services. *Conclusion.* The approach taken goes beyond individualistic approaches of health promotion and provides suggestions to improve future research, policy and practice. It identifies stigma as a crucial element to address when promoting sexual health. Importantly, this study focuses on tackling social and health inequities and in doing so advocates for human and women's rights.

**Keywords:** Opioid substitution treatment; Inequalities; Sexual Health; Sexually Transmitted Infections; Blood-Borne Viruses; Intersectional stigma; Intersectionality Theory; Women's Studies.

## Introduction

Social inequities involve disparities within different social groups, including women and substance users, that arise from an unequal social, economic and political power. Social inequities involve a violation of human rights as different communities and populations are unequally deprived from exercising their civil, political, economic, social and cultural rights (Krieger, 2014; World Health Organization, 2018a). Health inequalities are defined as differences in health status or in the distribution of health determinants between different populations. On the other hand, inequities refer to unnecessary, avoidable, and unjust access to health. Inequities are often the result of health inequalities (World Health Organization, 2018b). The term inequity is used throughout this paper as opposed to inequalities. Health inequities refer to preventable differences between social groups, to access resources to improve and maintain health and health outcomes. These differences are also evident in the disparities in the quality of health and healthcare access across different populations or communities (World Health Organization, 2018a). Both social inequities and health inequities are, at their core, a violation of human rights.

One source of health inequities is stigma. Initial theoretical understandings of stigma were developed by Erving Goffman, who defined stigma as a '*mark*' of an attribute that was socially devalued (Goffman, 1963). According to Goffman, stigma should be understood as a '*language of relationships, not attributes*' (p.3). Stigma results from the dichotomy between socially devalued and socially valued attributes, and maintains social inequities by segregating individuals into stigmatised and non-stigmatised groups (Earnshaw and Chaudoir, 2009). More recent conceptualisations of stigma have critiqued definitions which overlook the experiences of stigmatised individuals, and taken an individualistic approach (Link and Phelan, 2001; Link and Phelan, 2014; Deacon, 2006). These approaches have defined stigma as a social process shaped by the social context and the contingencies of social, economic and political power (Deacon, 2006; Link and Phelan, 2014; Link and Phelan, 2001; Joffe, 1999). When people assign labels to human differences, dominant cultural beliefs and social

norms give meaning and value to these labels (Link and Phelan, 2001). Stigma can also be considered as a form of symbolic power, as social power might be gained through stigmatising *other* individuals and/or social groups (Link and Phelan, 2014; Link and Phelan, 2001; Bourdieu, 1987). In this paper, stigma is defined as '*a social process involving the segregation of individuals and social groups, based on socially valued and devalued attributes that are contingent on inequities in social, economic and political power*'. The term "stigma" will be used generically to refer to any experience of stigma, whereas the use of the plural term "stigmas" will be used when referring to the experience of multiple and distinct stigmas. Particular terms will be used for specific types of stigma.

Drug-using populations experience social and health inequities. People using drugs are at higher risk of numerous health conditions, including sexually transmitted infections (STIs), HIV and other blood-borne viruses (BBVs) (i.e., Hepatitis B and C) (Cavanaugh *et al.*, 2010; Des Jarlais *et al.*, 2011; Hwang *et al.*, 2000; UNAIDS, 2014, 2016, 2015; World Health Organization, 2016a, d, b, c). This heightened risk can be explained, not only due to unsafe drug use (i.e., sharing needles and paraphernalia when injecting drugs), but sexual risk behaviours (i.e., condomless sex) that results from vulnerability to violence and the associated sexual health risks out of women's control (e.g., condoms are commonly not used in non-consensual sex) (Booth *et al.*, 2000; Tyndall *et al.*, 2002; Strathdee, 2003; Strathdee and Sherman, 2003; Strathdee and Stockman, 2010; El-Bassel *et al.*, 2011; El-Bassel *et al.*, 2005; Des Jarlais *et al.*, 2011; Edelman *et al.*, 2014; Kulesza *et al.*, 2016). Ultimately women are particularly at risk of violence mostly because of gender inequities that stem from socially constructed gender roles based on unequal socioeconomic and political power (Moss, 2002; Palència *et al.*, 2014; Dunkle *et al.*, 2004; El-Bassel *et al.*, 2005; El-Bassel *et al.*, 2011). There is however a lack of research on gender-related stigma among drug-using populations.

People using drugs are a highly stigmatised group (Kulesza *et al.*, 2016; Earnshaw *et al.*, 2013; Room, 2005; Luoma *et al.*, 2007; Lloyd, 2013; Link *et al.*, 1999). Experiencing stigma has been associated with poor adherence to medication, poor help-seeking behaviour and may be associated with sexual health risks (Vanable *et al.*, 2006; Earnshaw and Chaudoir, 2009). However, the evidence is conflicting and suggests variable relationships between different dimensions of stigma and health

outcomes (Varni *et al.*, 2012; Earnshaw and Chaudoir, 2009). Drug use-related stigma often overlaps with stigma associated with other interdependent social categories (e.g., female gender, transactional sex – the exchange of sex for money and/or goods, including drugs – HIV status, race, social class, incarceration history, weight, and sexual orientation) (Mahajan *et al.*, 2008a; Stangl *et al.*, 2013; Chambers *et al.*, 2015; Sangaramoorthy *et al.*, 2017; Loutfy *et al.*, 2012; Parker and Aggleton, 2003; Kulesza *et al.*, 2016; King *et al.*, 2013; Bowleg, 2008; Deacon, 2006; Deng *et al.*, 2007; Shields, 2008; McCall, 2005; Rice *et al.*, 2018). Personal and social identity can actually be understood as multidimensional, rather than the unidimensional product of a combination of personal attributes and belonging to certain social groups (Deaux, 1993; Rosenberg, 1988). Taking this approach, an individual can experience multiple overlapping stigmas (intersectional stigma), that refer to associations between social identities and structural inequities (e.g., in relation to gender or engaging in transactional sex).

This study is part of a project that aims to develop a sexual health service for women receiving opioid substitution treatment (WOST) in community pharmacies in England (UK). The focus of this paper is on how experiences of stigma may shape sexual health among WOST. The present study aims to explore the experiences of intersectional stigma among WOST, an accessible group within drug-using populations through healthcare services. Presented in this paper are the findings on the potential relationship between the experience of stigma and sexual risks among women on opioid substitution treatment. This paper addresses two research questions: 1) What are the experiences of stigma of WOST?, and 2) How does experiencing stigma influence women's sexual health?

## **Methods**

Twenty semi-structured face-to-face interviews were conducted with WOST. The interviews were conducted at two drug services in Bath and Midsomer Norton (UK) (n=19) and a service for sex workers in Bristol (n=1), in a seven-month period (October 2016 - April 2017). All interviews were audio-recorded and transcribed verbatim. The interview schedule was devised based on the study's aims and objectives, previous research, and inputs from a patient advisory group. The focus of the interviews were on perceived sexual health risks and women's experiences of receiving opioid substitution

treatment in community pharmacy. Data collection and analyses were conducted by the lead author, supervised by the other authors.

### **Recruitment Strategy**

A venue-based sampling method was used for this study as it is often successful for recruiting hard-to reach populations such as WOST (Muhib *et al.*, 2001; Thomas and Freisthler, 2016; Weir *et al.*, 2012; Raymond *et al.*, 2010). Participants were opportunistically recruited in two drug services and a service for sex workers. The services' staff acted as gatekeepers by identifying eligible participants. The inclusion criteria were (1) women, (2) over 18 years of age, and (3) on/having received opioid substitution treatment. The researcher (LMP) introduced herself and the study to potential participants and gave women the opportunity to ask questions and express concerns. Once women agreed to take part in the study, the researcher either conducted the interview on the same day or agreed to meet at a future date when the participant had an appointment at the service. The researcher (LMP) approached 75 women to take part in the study: 20 agreed (26.6%) and 55 declined (73.3%). The number of women informed about the study by the services' staff is unknown to the researchers.

### **Procedure**

Participants took part in a semi-structured face-to-face interview for around one hour (between 25 – 80 mins). The interviewer adjusted the timings of the interviews based on women's needs (some participants had other appointments, or felt unwell during the interview). Written and verbal consent were obtained before the start of the interview. All women were made aware of their right to opt-out of the study until data analysis and of non-disclosure. After the interview, all participants were asked to fill in a non-standardised questionnaire including questions on demographics, drug use and sexual history and sexual health. All participants were given a verbal and written debrief, and a £10 shopping voucher to thank them for their participation.

This study obtained ethical approval from the English National Health Service (NHS Ethics: IRAS Id. 20570, REC 16/NW/0432) on 17<sup>th</sup> August 2016. Quotes are reported verbatim and the names of the participants have been changed to ensure anonymity.

## **Data Analyses**

This study followed an inductive, interpretivist and constructionist approach. It thus frames “reality” as socially constructed and embraces interpretation and subjectivity within the research. The researchers’ values are thus an element influencing the research process. We have sought to ensure the quality of this research by being sensitive to the context of the research, using theory and methodology rigorously, offer transparency and coherence, and ensuring the impact and importance of this study (Yardley, 2017).

The interviews were analysed using Framework Analysis (FA) (Ritchie and Spencer, 1994), an approach to analysing qualitative data. The aim of FA is to classify and organise the data according to key themes, in order to develop a hierarchal thematic framework. FA is a case- and theme-based approach, as it allows the combination of data from particular participants and the analysis of data across participants. Contrary to other methods, FA manages summarised data rather than “raw” or original data, although the link to original data is always retained. There are five stages to FA: 1) familiarisation with the data, 2) identifying a thematic framework, 3) indexing, 4) charting, and 5) mapping and interpretation. For more details on the different steps of FA see the original paper by Ritchie and Spencer (Ritchie and Spencer, 1994), and the work by Gale et al (Gale *et al.*, 2013). The first author led the conduct of the analysis. All of the authors were involved to varying degrees in clarification and adjustment of the analysis. The relevant data can be obtained on request from the first author. The analysis was assisted with NVivo10 software. Descriptive analyses were performed to analyse the data from the questionnaires, using IBM SPSS Statistics 22 software.

## **Results**

### **Participant Characteristics**

#### **General demographics**

Twenty women aged between 27 and 56 ( $M=39.50$ ,  $SD=9.65$ ). Eighteen women were British (90%), one was White European (5%) and one was Black African (5%). All participants had English as their primary language. Eight women had no academic qualifications (40%), seven had finished secondary

school education (35%), three had finalised university entry-level education (15%), and two completed undergraduate studies (10%). Most participants (n=16) were not working at the time of the interviews (80%). Also, 16 women had an annual income below £10,000 (80%). Most women were “in a relationship” (n=8, 40%) or “single” (n=7, 35%) when they took part in the study. Women had between none and five children (M=1.58, SD=1.39).

### **Opioid substitution treatment and substance use**

All women were receiving opioid substitution treatment (OST). Fourteen were on prescribed methadone (70%), five on buprenorphine (25%), and one on Suboxone – a combination of buprenorphine and naloxone – (5%). Three participants were in the last stage of drug addiction, and they were taking small doses of OST. Two others had recently started OST. All participants currently used other drugs. The most commonly drugs of use were: tobacco (n=20, 100%), heroin (n=18, 90%), alcohol (n=17, 85%), crack cocaine (n=15, 75%), benzodiazepines (n=15, 75%), cannabis (n=15, 75%), and codeine (n=13, 65%).

### **Sexual history and sexual health**

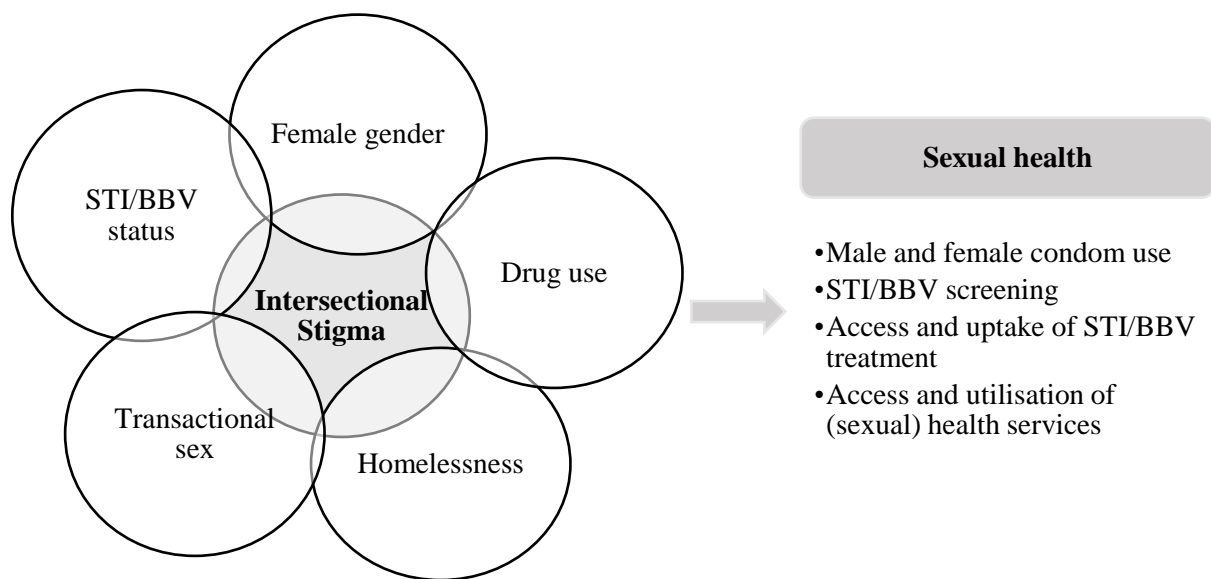
Most women had had sex with men only (n=14, 70%), five with both men and women (25%) and one with women only (5%). Eight women had engaged in transactional sex at some point in their lives (40%). Most women reported having been sexually abused (n=17; 89.5%).

Eleven women were currently not having sex (55%). Of the ones that were sexually active, five did not use any methods to prevent STI/BBV transmission (55.5%), and four used male condoms (44.4%). Most women had screened for STIs and BBVs at least once (n=17, 83.3%). Seven women had been diagnosed with Hepatitis C (35%), four with chlamydia (20%), two with genital warts (10%), two with pubic lice (10%), two with scabies (10%), one with gonorrhoea (5%), and one had the human papillomavirus (5%).

### **Main Findings**



Our findings suggest that intersectional stigma seemed to be associated with sexual health. Women's experiences of intersectional stigma were associated with female gender, drug use, women's engagement in transactional sex, homelessness, and STI/BBV status (see Figure 1). The intersection of women's interdependent stigmatised identities shape women's social identities and social and health inequities. More specifically, intersectional stigma was associated with a lack of condom (male and female) use, and was a barrier to accessing (sexual health) services.



*Figure 1.* Intersectional stigma and sexual health among WOST.

### **Gender-related stigma**

All women in this study had experienced gender-related stigma (i.e., a social process involving the social devaluation of individuals of the female gender). Gender-related stigma was rooted in normative socially-constructed gender roles (e.g., women are expected to be accommodating). These roles led to gender inequities and women's limited access to social and economic *power* in relation to men. Stigma based on their female gender was particularly embedded within their relationships with sexual and romantic partners but was also present in women's relationships with family members, and other people within women's' social network.

*“Yeah, if you say something, or even if you hit them [partner] back (...) Then it gets worse because they have to be the powerful one. They always have to be the one that it’s in control and more powerful” (Emmeline, aged 35).*

Through women’s narratives, it became clear that women had themselves internalised this stigma in relation to their gender. Women often perceived themselves as subordinate to men, and often acted accordingly to these gendered social roles. For instance, some women mentioned how providing condoms was a *“man’s thing”* and they delegated the responsibility of carrying and providing condoms to men. Carrying, providing and negotiating condom use was then not within the expectations of the female gender. Women were also fearful of being stigmatised if they breached these gendered expectations. Women expressed how they could be judged as *“being too keen”* if carrying condoms and trying to negotiate their use. This was also apparent when women disclosed feeling embarrassed to carry condoms, especially female condoms. Only a few women had used female condoms, and overall women did not perceive female condoms to be a viable option to prevent STIs and BBVs (and pregnancy). Resistance to their use was constructed in terms of their effectiveness and how to use them. Female condoms were also rejected on the grounds of being *“too big”* and *“visible”*. On the other hand, extending the use of female condoms was recognised by some as an opportunity for women to gain power and equity in sexual encounters and in relation to men. A few women claimed the need for barrier and contraceptive methods *“for women”* as a means for empowerment and to reduce gender inequities. This suggests that gender-related stigma may however block women’s confidence and willingness to gain control over their sexual health and sex life. Overall, sex was perceived to be *“for men”* rather than being an experience of equity. Given that negotiating condom use often led to a confrontation, some women avoided suggesting using condoms.

Based on women’s narratives, gender inequities and gender-related stigma often translated into gender-based violence. Almost all women in this study disclosed having experienced gender-based violence, usually perpetrated by men. This took a range of forms: psychological, physical and sexual. Sexual violence included sexual harassment, intimate partner sexual violence, sexual exploitation (e.g., when being coerced to engage in transactional sex), sexual violence in transactional sex encounters,

sexual assault, and child sexual abuse. Intimate partner violence (IPV) was most commonly referenced. It included psychological, physical and/or sexual violence. Experiencing IPV appeared to be associated with women's lack of control over their sexual health. Condomless sex was usually the norm within steady relationships. Condoms were perceived to create a barrier for building trust and intimacy within steady relationships. Feelings of love and trust were associated with women not using condoms, as "feeling for" one's partner was perceived to justify (and even eliminate) sexual health risks. In situations of IPV, condomless sex was often forced and women felt powerless to make decisions regarding their sexual health. Sexual violence was often combined with the threat or actual psychological and/or physical violence. Women often explained how they were forced to "consent" to having condomless sex to avoid other violent events. In some occasions, sexual violence resulted in unwanted pregnancies and STI/BBV transmission.

*"He had a thing about not wanting ever to use condoms and we had like a bad, violent, like he beat me up basically, quite a few times. And so in the end I just ended up just doing what he wanted it, just cause it's easier" (Sylvia, aged 27).*

Women had internalised these socially constructed gendered roles. Some women disregarded situations of violence as they viewed them as part of their role as women. This was related to the belief that women belonged to the "weaker gender". Women perceived themselves as not being "strong enough" and they often blamed and judged themselves for being disempowered and in a socially unequal position. Occasionally, significant others' encouraged women to continue violent relationships, claiming it to be a "woman's duty" to endure violence as a sign of "love" for their partners. Situations of IPV were thus maintained through gender inequities and gender-related stigma.

*"[IPV] was years ago now and to be fair at the time I didn't really... think anything of it. It's only as I got older that I realise that it was really wrong... (...) Yeah... he sort of brainwashed me into thinking that I owed him sex" (Rosa, aged 40).*

There was a general lack of understanding of what constituted gender-based violence. It was seen as a continuum so that violent situations were not always identified as such and, on some occasions,

women would only give meaning to violent events retrospectively. Perceiving gender-based violence as a more or less serious event(s) also led to women not identifying situations that were socially categorised as being less serious as violence. Women's narratives also suggest that women can hold themselves responsible for experiencing gender-based violence. Again women themselves disclosed gender-related stigma, and placed the roots of gender-based violence in women's expression of socially constructed ideas of *femininity*.

*"I think women need to put their feet down and stop showing that feminine side of them and show their strong side. They might actually get somewhere to make a man wear a condom in the relationship" (Teresa, aged 34).*

Women also disclosed how they generally felt oppressed and defenceless; feeling powerless over their own lives. They were often forced to engage in transactional sex to provide money and drugs for their partners (and eventually themselves), in steady relationships. Drug dealers also forced women into transactional sex. Women frequently received sexual propositions by men, and were often coerced into exchanging sex for drugs and/or to pay debts. These sexual exchanges rarely included the use of condoms, and were sometimes violent.

Seeking social and professional support was a difficult undertaking. Women often distrusted authority figures (e.g., police and health professionals), which left them feeling helpless. On some occasions, women had received support from family members, friends or neighbours. A few went through legal proceedings for IPV. Several women had been threatened and harassed by their ex-partners regardless of restraining orders or prison sentences. Women were again left feeling defenceless despite the legal sentence, *"Until he's not done, until he's not done that [killing her] there's nothing they can do"* (Florence, aged 37). Other forms of violence (e.g., child sexual abuse or physical/sexual assaults) were rarely disclosed or reported to the police. Women were usually reluctant to seek professional psychological help to address and reframe the violence that they had experienced.

Some women openly acknowledged the injustice of gender-related stigma, and even called for social and political action. Women were angry, and felt powerless, helpless and hopeless. They were looking for opportunities to be heard and to contribute to tackling gender-related stigma.

### **Drug use-related stigma**

Drug use-related stigma (i.e., the social process in which drug-using populations are devalued) was experienced by all women in this study. Drug use-related stigma was embedded within community and social norms. There was a manifest “*blame culture*” in which women were blamed for their drug use. The women felt that the public did not know the nature and complexity of addiction and drug use-related issues. Negative attitudes and beliefs towards WOST seemed to shape and reduce women’s identity to “*just junkies*”. WOST were then assigned to the “*not normal*” group, the “*unwanted outliers*” that did not *belong* and were excluded from society. This even translated into women feeling a *loss of their humanity* because of their drug using patterns. Women’s identity as a drug user was perceived to be unchangeable, “*I will always be an addict*” (Marie, aged 29). Women felt invisible and worthless of love and affection, “*and you feel worthless as well, so like if you get the chance, if someone liked me or you know loved me or somethin’*” (Florence, aged 37).

Women experienced overt stigmatisation from loved ones and other people making them aware of negative societal attitudes towards drug use. It led to women losing their relationships with family members and friends, and losing touch with their identities prior to starting using drugs. Drug use was a source of shame and increased worthlessness, which led to fear of disclosing drug use. Non-injecting women perceived themselves in a *higher social* position compared to those who injected drugs. This suggested a *hierarchy* in the levels of drug-related stigma among WOST, depending on their injecting/non-injecting status.

“*It’s dirty, it’s dirty so you can yeah. That’s what they’ve [people] said about me before and I haven’t even injected. It’s just the whole thing... And I was with my family, my dad’s girlfriend like started all that [stigmatisation] off, so that [stigmatisation] was in my family... quite horrible...*” (Sylvia, aged 27).

Women's experiences and engagement with social and health care services was dependent on how stigmatised and dehumanised women felt attending these services. Some women experienced open discrimination in community pharmacies from other pharmacy clients, when they were taking their opioid substitution treatment. Drug use-related stigma was also associated with the stigma attached to opioid substitution treatment, and especially methadone. Women felt isolated and defenceless as other pharmacy staff present would often not intervene, allowing stigmatising and discriminatory comments. Overall, women had learnt to distrust the system.

*"Certain chemists I've been to they just look at you all up like a drug user basically (...) cause they're getting their meth, so... it's just drug use... (Sylvia, aged 27).*

Women had internalised drug use-related stigma. Internalised stigma lowered women's sense of self-worth, and was a barrier to engaging in health protective behaviours (e.g., using condoms) and accessing services. Women felt powerless to change their situation, mainly when their lives were dominated by drug-seeking and drug-using behaviours. They experienced shame and self-blame, which seemed to be associated with a delay or avoidance of social support and professional help-seeking for (sexual) health. In such situations, maintaining health and preventing disease were not within women's priorities or concerns. For one woman, getting a terminal BBV had been seen on several occasions as preferable to the situation she was in day to day.

*"Sometimes you hope that you catch something, or... you know, because... to take you away from it all... you don't wanna live like this. There's many times that I've felt like that" (Florence, aged 37).*

### **Transactional sex-related stigma**

Women's narratives showed that transactional sex is highly stigmatised. This was the experience of women both who had engaged in transactional sex and those who had not. The latter were sometimes stigmatising towards the former. All women seemed to understand the pathways towards initiating transactional sex, and had been offered the opportunity to exchange sex for money or drugs.

Sex was a survival tool for those women who sold sex. Those who did not, often engaged in illegal activities (e.g., theft) to sustain themselves and in some cases their family. Drug dealers (and romantic partners in some cases) initiated women into transactional sex. Women reported that dealers could be quite coercive taking advantage of their vulnerable position, especially when they were in drug withdrawal and were then more likely to use drugs *at all costs*. Women were *sexually objectified* and reduced to the sum of their body parts and their sexual function, *“I am not a doll”* (Amelia, aged 52). This exemplifies intersectional stigma among WOST. Gender and drug use-related stigma appeared to be associated with women’s initiation into transactional sex, and transactional sex-related stigma.

*“Yeah, yeah. Most of them [dealers] will ask [for sex] and they know when you’re at your lowest. They can see it a mile away. It’s like they are predator aren’t they?”* (Emmeline, aged 35).

Transactional sex workers tended to use male condoms consistently with clients, in this situation commonly being the ones to provide condoms and initiate the negotiation of condom use. Women used condoms to create an emotional barrier to cope with transactional sex. Using condoms somehow allowed transactional sex workers to feel empowered and increased their sense of self-worth. Women expressed confidence when negotiating condom use with clients, as opposed to their fear and lack of confidence with romantic partners. Clients often suggested having condomless sex in exchange for a larger amount of money. Most women refused to engage in condomless sex with clients. Some women agreed, often based on the client’s appearance, *“If they are a horrible old guy you just say “No”, but if they are a young guy, fit and all you think “Oh, yeah””* (Harriet, aged 41). Other times, women felt forced to engage in condomless sex not to lose clients to other workers. Some clients were violent and forced condomless sex when women refused to have sex without using condoms. Negotiating the price of transactional sex services had to be done carefully. Transactional sex-related stigma was higher among women who exchanged sex for lower amounts of money, and street workers, as opposed to other transactional sex workers. Women’s decisions over selecting clients and using condoms were dependent on how high/low women were within the social hierarchy among transactional sex workers, and related stigma.

*“It depends on the level you are at. If you are a street worker no, not so much. You are pretty much lower than low. Depending on what level you are, it’s like when I was working I said that if I didn’t want to go with a client I didn’t. If he wouldn’t wear a condom it wouldn’t happen. And someone stood outside the door and things like that, you know what I mean so it was all about doing it properly...” (Joan, aged 27).*

Gender-based violence was common among transactional sex workers. Women used systems of protection to prevent situations of physical and sexual violence (e.g., telling other workers about their location). However, women felt constantly at risk, especially when working in the street. Given that transactional sex is criminalised in the UK, women felt defenceless and did not always report violent encounters with clients to the police. Women felt that legislation did not protect their safety nor the clients’. Transactional sex was often not disclosed to family and friends, due to the fear of being stigmatised, discriminated and even socially excluded. One participant also mentioned how she only sold sex to strangers to prevent men who knew her trying to “buy her” (Amelia, aged 52).

The only place where transactional sex workers did not feel stigmatised was a service for sex workers, where one of the participants was interviewed.

*“But, you know, the emotional and psychological support is... is the one place where we don’t feel hmm... beneath, at the bottom of the pile... you know, the muck off someone’s shoe, you know... We are people here, you know, we are just women.” (Amelia, aged 52).*

### **Homelessness-related stigma**

Women’s experiences of homelessness were tainted by stigma. Women living on the streets felt socially isolated. They felt invisible, judged and mistreated by other people, to the extent of being dehumanised. Women advocated that stigma and the resulting social exclusion and misrepresentation of homeless people should be addressed by educating people about homelessness. There was an intersection of drug and homeless-related stigma, as homeless people who used drugs were perceived to have a lower social status.



*“Yeah, you are like an animal, you are not the same. People that are selling the “Big Issue”, people get looked at like nothing, like “I’m not getting nothing. I’m not giving you money”. But they don’t... it’s hard to explain that you don’t want that money, you need that money” (Emmeline, aged 35).*

Homelessness-related stigma often led to random violence, including physical and sexual assaults. Violence was more prevalent towards homeless women. Homeless women got sexual propositions daily, which reflects the sexual objectification of women and relates to gender-related stigma. Drug use was sometimes initiated to cope with homelessness, rather than drug use leading to homelessness. Women felt defenceless as violent assaults were either unreported or disregarded by police officers, who also were stigmatising towards homeless people. The police and other government workers were then untrusted, which reinforced women’s feelings of helplessness.

*“That first... we don’t go to the police because they can’t be trusted, they are the enemy of the homeless people. There’s nowhere we can go where we can say they’re on our side” (Joan, aged 27).*

Homeless-related stigma also manifested at the structural level. Homeless women could not access health services easily, as they thought that they could not register with a general practitioner because they did not have an address. Other restrictions and the lack of services for homeless people prevented homeless women accessing (sexual) health services. It seemed that women living on the streets were even more socially excluded and invisible. Women expressed how health policies do not seem to address the needs of homeless women. This may further emphasise homeless women’s feelings of having been assigned to the “not normal” and “unwelcomed part” of society.

*“But as it stands now the only place that we can go to is our GP. Well I don’t have a GP so that is a problem” (Joan, aged 27).*

### **STI/BBV status-related stigma**

Women’s narratives highlighted sex and sexual health as taboo and stigmatised topics. Some women were embarrassed to discuss sex and sexual health, although some were not. Stigma related to

STI/BBV status (i.e., the social process in which individuals that have an STI or a BBV are socially devalued) is rooted in these social taboos. A few women in the study had been diagnosed with Hepatitis C. The diagnosis usually was accompanied with feelings of guilt and self-stigma (i.e., stigma directed to oneself) that made women want to isolate themselves socially, *“Yeah, I feel I’ve got dirty blood running through me at the moment. So I’m having a bit of a wall on me at the moment because of it” (Jane, aged 51)*. Women’s feelings of worthlessness made them feel *“not worth living”*. Feeling love was a way for women to feel more valued and feel worth enough to take steps to protect against STIs and BBVs.

*“Until you have someone that loves you as well and you think ‘Oh, life is worth living. It’s not worth catching HIV...’, you know all the [infections] it’s not worth catchin’ you know...” (Florence, aged 37)*.

Disclosing an STI or BBV positive diagnosis was a challenging undertaking that women feared. Compared to men, women were considered *“slags”* and *“sluts”* if they had an STI or BBV. This was directly related to sex as a taboo topic, and the intersection between gender and STI/BBV status-related stigma. STI and BBV-related stigma was high, especially as an STI/BBV diagnosis was often associated with using drugs and intersected with drug-related stigma. None of the women interviewed for this study disclosed a HIV positive diagnosis. However, women’s narratives highlighted that although stigma around HIV had reduced over the past few years, it was still high and could lead to social isolation and shame. HIV was perceived to be more stigmatised than other BBVs and STIs.

Women felt judged accessing sexual health services. They thought of other people thinking that they had *“done something dirty”*. Some women recalled having had negative experiences with health professionals during sexual health consultations. Health professionals were often stigmatising and judgmental towards women and discouraged them from seeking help for sexual health concerns. The lack of trust and fear of stigma from health professionals and other service users set a barrier to women accessing sexual health services. Women highlighted the need to enhance professionals’ consultation and communication skills, to reduce drug use and STI/BBV-related stigma.

*“Hmm... well when you go to a sexual health clinic everyone knows what you’re there for, you know what I mean? You get to the place where everyone is sitting there and you don’t know what they’re thinking, if they’re thinking ‘Oh, she’s got Chlamydia’.” (Marie, aged 29).*

There was an overall a lack of knowledge around STIs and BBVs. According to women, the main education agents (school teachers and parents) usually restricted the amount of information given, due to stigmatising views on sex and sexual health. Women learned about sex and sexual health through the media, peers, and personal experience. Women highlighted the importance of improving sexual health education in the UK to reduce the taboos around sex and sexual health, and ultimately prevent STI/BBV transmission and unwanted pregnancies.

## **Discussion**

Women in this study experienced stigma based on interdependent identities related to their gender, drug use, involvement in transactional sex, homelessness and STI/BBV status. This intersectionality of stigmas creates unique experiences of social exclusion and marginalisation that map on to social inequities. For example, WOST who are also homeless and engage in transactional sex may have a qualitatively different experience of stigma, and encounter higher levels of stigma, compared with WOST who are not homeless or transactional sex workers. In all cases, intersectional stigma seems to increase social invisibility. Women in this study expressed how they were disregarded by the system (healthcare, legal, political system). This socio-structural neglect has disempowering effects that appear to have an influence on women’s sexual health behaviours (i.e., using condoms), and access to (sexual) health services (e.g., sexual health screening or treatment uptake).

Health behaviour and outcomes have traditionally been approached at the individual level. However, health and well-being are not excluded from the influence of social and structural elements (Jetten J., 2012; Johnson and Acabchuk, 2018). Intersectionality approaches have been a central tenet of feminist research in the last few decades, and it has engendered activist science to inform policy towards addressing social and health inequities. Intersectionality goes beyond individual-level factors

to explore social and structural elements of social (and health) issues (e.g., gender-based violence) (Warner, 2008; Shields, 2008; Mahajan *et al.*, 2008b; Campbell C., 2006; Crenshaw, 1989; Hancock, 2007), and should be applied to approaches to promote sexual health among women using drugs (Auerbach and Smith, 2015).

Social identity approaches such as Social Identity Theory (Tajfel, 1979, 1986) and the Self-Categorisation Theory (Turner, 1987, 1985), can provide an explanation on how intersectional stigma may be related to women's sexual health. According to social identity approaches, individuals form a sense of self through their belonging to distinct social groups. The findings from this study seem to indicate that intersectional stigma, and the associated socio-structural neglect, may shape women's identity. Women felt undeserving of good health as a result of this shaped identity and did not feel worth enough to engage in health protective behaviour, such as using condoms or screening for sexual health. This debunks the assumption that everyone wants to be healthy, and thus presents a great challenge when promoting sexual health among WOST.

Our study suggests that individual-level explanations for sexual health should be replaced by approaches that acknowledge the impact of social and structural determinants of health. Our findings highlight gaps between the sexual health needs of WOST, and healthcare services and policies addressed to this group of women. They also highlight the need to provide specific sexual health services to WOST, and improve the quality of services that are already being offered to them. Awareness of the stigmas that exist towards this group should be an essential element of health professionals' training, and more inclusive policies that account for the link between stigma and sexual health should be developed. It is also important to address the blame culture in relation to drug-using populations. This comes with re-prioritising the aims and focus of sexual health strategies, towards a more humanistic health promotion strategy that addresses social and health inequities and advocate for human rights.

Feminist approaches are also an urgent issue to aim for equity between women and men and tackle gender-based violence. Safeguarding guidelines for professionals working with WOST should

be created, to identify and address gender inequities and gender-based violence. These should include sexual exploitation through the coerced initiation to transactional sex. Equity should also be the aim of educational programmes on sexual health, to further challenge the current patriarchal system. Creating and implementing policies to decriminalise transactional sex are an ongoing debate. Our findings support previous claims on positive links between decriminalisation of transactional sex and positive sexual health (Decker *et al.*, 2015; Weitzer, 2009; Morton *et al.*, 2002). Improvements to policy should not only incorporate gender inequities into their agenda, but also the existent and prevalent social (and associated health) inequities among homeless people and those with an STI or BBV diagnosis.

## **Limitations**

There are limitations to this study. Firstly, this study may have overlooked the complexity of interrelations between intersecting stigmas as other relevant identities of WOST (e.g., race, sexual orientation or legal status) were not explicitly studied. Secondly, the cross-sectional and qualitative design of this study cannot infer causality, neither explain how disadvantage accumulates through experiencing different intersections of stigma and its impact on sexual health. It should also be acknowledged that the data analyses were influenced by the researchers' values and subjective interpretation of the data; it is feasible that other researchers would have identified different themes in the data. Thirdly, data were collected in a small geographical area. Findings may not be transferrable to other geographical areas.

## **Conclusions**

This is the first study to use intersectionality theory to investigate stigma among WOST. The findings highlight the complexity and intersection of stigmas among WOST, in relation to women's female gender, drug use, involvement in transactional sex, homelessness, and STI/BBV status. This study suggest that intersectional stigma shapes women's identity, and is associated with a lack of male and female condom use, and a lack of access to (sexual) health services among WOST. Findings can

inform future research, the development of policies and protocols to address stigma, and design and improve (sexual) health services for WOST, including those in community pharmacy.

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